SPF SIG TRAINING MANUAL
SECTION 9B
RESOURCE ASSESSMENT

Objective: To know how to complete a resource assessment of prevention strategies occurring in your community that are impact a specific SPF priority issue.

This section of the Training Manual will review the Resource Assessment Survey Tool that can be found at the end of this section. The purpose of a Resource Assessment is to have more data and information that will assist you in prioritizing what factors you will want to address with your strategy(ies).

The Resource Assessment will arm you with the knowledge of what is already being done in your community to impact a specific priority issue. This is especially helpful when you begin the process of selecting a strategy. You do not want to duplicate services; you want to fill the gaps. After completing the Resource Assessment, you may know where you can build capacity in your community.

Below you will find the Resource Assessment Survey. The narrative that follows explains the individual questions as well as provides examples and definitions of the different factors and strategies. The Resource Assessment Survey Tool will need to be completed and then submitted to the State.

Resource Assessment Survey

Copy and complete the following table for each prevention program, policy, and/or practice that targets your priority issue:

<table>
<tr><td>Today's Date:</td><td colspan="3">Agency Name and Contact Information (Address, phone and email):</td></tr>
<tr><td colspan="2">a) Is this resource a program, policy or practice?</td><td colspan="2">( ) Program ( ) Policy ( ) Practice ( ) Other [Please explain:]</td></tr>
<tr><td colspan="2">1) What is the name of the program, policy, and/or practice and brief description?</td><td colspan="2"></td></tr>
<tr><td colspan="2">2) What is the target population of the program, policy, and/or practice?</td><td colspan="2"></td></tr>
<tr><td colspan="2">3) What SPF priority issue is this strategy addressing?</td><td colspan="2"></td></tr>
<tr><td colspan="2" rowspan="6">4) What are the causal factor(s) as well as the risk and/or protective factors targeted by the program, policy, and/or practice? Please list out each risk and/or protective factor within the appropriate domain.</td><td rowspan="6">( ) Availability
ARMVC only ( ) Retail ( ) Social
( ) Promotion
( ) Crim Justice/Enforcement
( ) Community Norms
( ) Individual Factors
( ) Provider Lack of Knowledge</td><td>Risk and Protective Factors</td></tr>
<tr><td>Family</td></tr>
<tr><td>Community</td></tr>
<tr><td>School</td></tr>
<tr><td>Individual/
Peer</td></tr>
<tr><td></td></tr>
<tr><td colspan="2">5) What agency or group delivers the program, policy, and/or practice?</td><td colspan="2"></td></tr>
<tr><td colspan="3">6) How many people (those targeted for change) will the program, policy, and/or practice reach during the current calendar year?</td><td></td></tr>
<tr><td colspan="2">7) a) What is the duration of the program, policy, and/or practice?
b) How often is the program, policy, and/or practice offered to the target population?</td><td colspan="2">a)

b)</td></tr>
<tr><td colspan="2">8) What prevention strategy does the program, policy, and/or practice use?</td><td colspan="2">( ) Education
( ) Environmental strategies
( ) Alternative activities
( ) Community-based process
( ) Problem Identification and referral
( ) Information dissemination</td></tr>
<tr><td colspan="2">9) What type of implementation data is collected?</td><td colspan="2">( ) Attendance ( ) Satisfaction ( ) Other [Explain]</td></tr>
<tr><td colspan="2">10) Is the program, policy, and/or practice evidence based?</td><td colspan="2">( ) YES ( ) NO
If yes, which agency(s) list contains the program, policy, and/or practice?
( ) NIDA ( ) CDC ( ) CSAP ( ) DOE ( ) Drug Strategies
( ) OJJDP ( )None of the above</td></tr>
<tr><td colspan="2">11) Has the implementing agency (as listed in Question 5) evaluated the outcomes of the program, policy, and/or practice?</td><td colspan="2">( ) YES ( ) NO If yes, explain.</td></tr>
<tr><td colspan="2">12) What geographical area is served?</td><td colspan="2"></td></tr>
<tr><td colspan="2">13) Is this strategy culturally appropriate?</td><td colspan="2">( ) YES ( ) NO If yes, explain how:</td></tr>
</table>

Note: These terms are in the order used on the Prevention Resource Assessment Survey form.

a. *Specify: Program, Policy, or Practice* – Please indicate whether the described resource is a program, policy, or practice. If none of the above, please check other and provide an explanation.

1. *Program, Policy, and/or Practice Name and Description*– Common name of the program, policy, and/or practice and a one to two sentence description of strategies and goals.

2. *Target Population* – The target population is the group of people that the program, policy, or practice is intended to influence, e.g., youth, adults, parents, community at large, etc. If the program you're describing has criteria that people must meet before they are allowed to participate in the program, such as age group, membership in an ethnic group, gender, or other criteria, for example, lacking health insurance, then please list those requirements also.

3. *SPF Priority issue focus* – Please identify which of the priority issues this specific intervention addresses.

4. *Targeted risk and/or protective factor and/or causal factors by domains* – Please indicate the causal factor(s) as well as any risk and/or protective factors that the program is intended to affect. If the intervention addresses one of the causal factors listed, please check the appropriate box(es). There is an explanation of each causal factor attached. Next, consult the attached list of risk and protective factors and list the corresponding number for each risk or protective factor that the program addresses within the appropriate domain box. For example, if the intervention is a parenting program that addresses family management issues, family conflict and parent-child bonding, you would indicate FR1 (poor family management risk factor), FR2 (family conflict risk factor) and FP1 (bonding) in the family domain box because all of the risk and protective factors addressed by this program fall within the family domain. While many interventions do target multiple causal factors and/or risk and protective factors, please think carefully about which factors are directly targeted by the activities of the intervention. If there is not a direct connection between the activities of the intervention and a causal/risk/protective factor, do not list that factor as a targeted factor.

5. *Agency or group delivering* – List the name and address of the agency or group that actually delivers the program, policy, and/or practice.

6. Reach – List the number of targeted individuals that will receive the program, policy, and/or practice during the current calendar year.

7. Duration – Part A: How often is the program, policy, and/or practice offered to the targeted population as part of one *complete cycle* of the program? For example, if you are implementing a parenting program that is offered 2 hours a day, once a week for 12 weeks, please indicate this in your response to question 7a. Part B: How many *cycles* of the program are offered per calendar year? For example, if the agency offers 3 cycles of the 12 week program per year, this would be indicated in the response to question 7b.

8. Prevention Strategies – The program, policy, and/or practice being implemented may employ more than one of the strategies to reach the targeted population. Please see the attached Prevention Strategies List for examples.

- Education involves two-way communication and is distinguished from the information dissemination strategy by the fact that interaction between the educator/ facilitator and the participants is the basis of its activities. Activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills, critical analysis (e.g., of media messages), and systematic judgment abilities.
- Environmental establishes or changes written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of substance abuse in the general population. This strategy is divided into two subcategories to permit distinction between activities that center on legal and regulatory initiatives and those that relate to the service and action-oriented initiatives.

- Alternatives provides for the participation of target populations in activities that exclude substance use. The assumption is that constructive and healthy activities offset the attraction to--or otherwise meet the needs usually filled by--alcohol and drugs and would, therefore, minimize or obviate resort to the latter.
- Community-based process aims to enhance the ability of the community to more effectively provide prevention and treatment services for substance abuse disorders. Activities in this strategy include organizing, planning, enhancing efficiency and effectiveness of services implementation, interagency collaboration, coalition building, and networking.
- Problem identification and referral aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if a person is in need of treatment.
- Information dissemination provides awareness and knowledge of the nature and extent of substance use, abuse, and addiction and their effects on individuals, families, and communities. It also provides knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two.

9. Implementation Data – Which types of implementation data are collected by the implementing agency? **Attendance/Reach** - Are there data to show the number of attendees enrolled and completing the program? Or, for broader policy or practice, are there data to show the number of people the policy or practice affects? For example, if the policy or practice applies to all residents of the city/parish/state and what's that population, the number for a school policy would be the number of students enrolled in the school. Alternatively, for a practice such as checking ID's at a fair/festival, then the number needed is the estimated number of attendees to that fair/festival. **Satisfaction** - Are there data to show attendee satisfaction with the program, policy, and/or practice? **Other** - Are there other types of data collected about the implementation of this program, policy and/or practice, such as intervention fidelity data? Please check all that apply.

10. E*vidence-Based Program, Policy, and/or Practice* – These are terms used by federal agencies to categorize prevention programs. Similar terms include "model programs" or "science based programs." A program must show positive results and meet scientific research criteria in order to be categorized as evidence-based. If the program is endorsed by one of the federal agencies listed as an evidence-based intervention please check the agency that endorses it. If the intervention is evidence-based but has not been endorsed by any of the listed agencies, please check "none of the above."

11. Program evaluation – Please indicate whether the implementing agency has evaluated the outcomes of the program. Outcome evaluations focus on measuring program effectiveness, e.g., change in knowledge, attitudes, behavior, or skills, whether randomized control trials or pre-test/post-test that the implementing agency conducts. If yes, please list/explain the types of outcome data collected, e.g., substance use, antisocial behavior, risk, protective or causal factor data, knowledge, skills, attitudes, etc.

12. Geographical area served – List exactly which area(s) the program, policy, and/or practice is delivered within. This may be a city, county, district or a school district.

13. Cultural Competency – Explain if this strategy is culturally sensitive and/or may be modified to reach a broader population.

Causal Factors

Definitions of specific Causal Factors:

Alcohol Related Motor Vehicle Crash factors

- Retail availability – Retail availability refers to the availability of alcohol through retail outlets. It may refer to the density of retail outlets, the ability of underage drinkers to obtain alcohol illegally through retail outlets, ways in which retail outlets encourage or allow drinking and driving or additional ways that you may identify in your community.

- Criminal justice/enforcement – enforcement or perception of enforcement of alcohol laws may be an important deterrent to problem alcohol use at both the state and community levels. Ask if there is enforcement of sales of alcohol to minors, possession of alcohol by underage drinkers, or lack of prosecution of alcohol related offenses?

- Social availability – social availability refers to the ways in which people obtain alcohol through social ties such as family members, friends, and the like. This includes both providing underage drinkers with alcohol as well as ways in which social availability encourages excessive drinking among of-age drinkers.

- Promotion – Promotion involves things such as low price specials by both on-premise and off-premise alcohol outlets contribute to drinking patterns in your community. Another way to review this factor is to look at the promotion of alcohol occurring through newspapers, billboards, TV or other media outlets. You may come up other ways promotion encourages heavy drinking and drinking and driving in your community.

- Community norms – Community norms are the informal rules of acceptable behavior that apply in community settings. Community norms can encourage or discourage problem alcohol-related behaviors.

- Individual factors – The individual factor category refers to a cluster of variables that characterize an individual's risk for engaging in problematic alcohol consumption. These individual factors may pertain to an individual's attitudes, temperament, genetic predisposition, family relations, etc. that affect their likelihood of engaging in problematic drinking.

Prescription Narcotic Morbidity and/or Mortality

- Provider lack of knowledge – Provider lack of knowledge refers to ways that health care professionals with prescription privileges (physicians, dentists, etc.) and pharmacists might inadvertently contribute to prescription narcotic misuse and abuse.

- Individual Factors - Individual factors refer to characteristics about individuals within your community that may affect their likelihood of abusing or misusing prescription narcotics. Individual factors can be similar to community norms in content, but refer to individuals rather than communities. Examples of individual factors include attitudes about prescription narcotics, including perceived risk of harm about sharing prescription drugs. Other individual factors include knowledge of proper use.

- Availability – Availability refers to the availability of prescription narcotics to members of your community by any means. It may refer to sharing between friends and family or it could refer to fraudulent prescriptions obtained for personal use or resale.

- Criminal justice/enforcement – Criminal Justice/Enforcement refers to the likelihood that individuals who abuse prescription narcotic drugs or otherwise break prescription drug laws (such as illegally obtaining or distributing prescription narcotics) will be discovered and penalized by the criminal justice system. Another aspect with this factor is the perception of enforcement by the community.

- Community Norms - Community norms refer to attitudes or practices that are common in your community that might directly or indirectly contribute to prescription narcotic morbidity and mortality. One important norm is perceived risk. You may look to see if community norms favorable towards prescription drug misuse and abuse. Some questions to ask are: What is the community's perception regarding the acceptability of sharing prescription drugs with family or friends (who have similar ailments)? What are the community norms regarding how to deal with leftover or extra pills? What is the community's perception of harm in using Rx Drugs in a non-directed manner? What is the community's perceptions regarding the general safety of using prescription narcotics?

Risk and Protective Factors

Family Domain Risk Factors	
Family History of Substance Abuse (FR1)	When children are raised in a family with a history of problem behaviors (e.g., violence or ATOD use), the children are more likely to engage in these behaviors.
Poor Family Management (FR2)	Parents' use of inconsistent and/or unusually harsh or severe punishment with their children places them at higher risk for substance use and other problem behaviors. Also, parents' failure to provide clear expectations and to monitor their children's behavior makes it more likely that they will engage in drug abuse whether or not there are family drug problems.
Family Conflict (FR3)	Children raised in families high in conflict, whether or not the child is directly involved in the conflict, appear at risk for both delinquency and drug use.
Parental Attitudes Favorable Toward Antisocial Behavior & Drugs (FR4)	In families where parents use illegal drugs, are heavy users of alcohol, or are tolerant of children's use, children are more likely to become drug abusers during adolescence. The risk is further increased if parents involve children in their own drug (or alcohol) using behavior, for example, asking the child to light the parent's cigarette or get the parent a beer from the refrigerator.
Family Domain Protective Factors	
Family Attachment (FP1)	Young people who feel that they are a valued part of their family are less likely to engage in substance use and other problem behaviors.
Opportunities for Positive Involvement (FP2)	Young people who are exposed to more opportunities to participate meaningfully in the responsibilities and activities of the family are less likely to engage in drug use and other problem behaviors.
Rewards for Positive Involvement (FP3)	When parents, siblings, and other family members praise, encourage, and attend to things done well by their child, children are less likely to engage in substance use and problem behaviors.
Community Domain Risk Factors	
Perceived Availability of Drugs and Handguns (CR1)	The availability of cigarettes, alcohol, marijuana, and other illegal drugs has been related to the use of these substances by adolescents. The availability of handguns is also related to a higher risk of crime and substance use by adolescents.
Community laws and norms favorable toward drug use (CR2)	Research has shown that legal restrictions on alcohol and tobacco use, such as raising the legal drinking age, restricting smoking in public places, and increased taxation have been followed by decreases in consumption. Moreover, national surveys of high school seniors have shown that shifts in normative attitudes toward drug use have preceded changes in prevalence of use.
Transitions and mobility (CR3)	Neighborhoods with high rates of residential mobility have been shown to have higher rates of juvenile crime and drug selling, while children who experience frequent residential moves and stressful life transitions have been shown to have higher risk for school failure, delinquency, and drug use.
Low neighborhood attachment (CR4)	A low level of bonding to the neighborhood is related to higher levels of juvenile crime and drug selling.
Community Disorganization (CR5)	Research has shown that neighborhoods with high population density, lack of natural surveillance of public places, physical deterioration, and high rates of adult crime also have higher rates of juvenile crime and drug selling.
Extreme economic deprivation (CR6)	Children who live in deteriorating and crime-ridden neighborhoods characterized by extreme poverty are more likely to develop problems with delinquency, teen pregnancy, school dropout, and violence. Children who live in these areas—and have behavior and adjustment problems early in life—are also more likely to have problems with drugs later on.

Community Domain Protective Factors	
Opportunities for prosocial involvement in community (CP1)	When opportunities are available in a community for positive participation, children are less likely to engage in substance use and other problem behaviors.
Recognition for prosocial involvement (CP2)	Rewards for positive participation in activities helps children bond to the community, thus lowering their risk for substance use.
School Domain Risk Factors	
Academic failure beginning in elementary school (SR1)	Beginning in the late elementary grades (grades 4-6) academic failure increases the risk of both drug abuse and delinquency. It appears that the experience of failure itself, for whatever reasons, increases the risk of problem behaviors.
Lack of commitment to school (SR2)	Surveys of high school seniors have shown that the use of hallucinogens, cocaine, heroin, stimulants, and sedatives or non-medically prescribed tranquilizers is significantly lower among students who expect to attend college than among those who do not. Factors such as liking school, spending time on homework, and perceiving the coursework as relevant are also negatively related to drug use.
School Domain Protective Factors	
Bonding and attachment to school (SP1)	Young people who feel that they are a valued part of their school are less likely to engage in substance use and other problem behaviors.
Opportunities for prosocial involvement in school (SP2)	When young people are given more opportunities to participate meaningfully in important activities at school, they are less likely to engage in drug use and other problem behaviors.
Recognition for prosocial involvement (SP3)	When young people are recognized and rewarded for their contributions at school, they are less likely to be involved in substance use and other problem behaviors.
Individual/Peer Risk Factors	
Early and persistent antisocial behavior (IR1)	Boys who are aggressive in grades K through 3 are at higher risk of substance abuse and juvenile delinquency. However, aggressive behavior before Kindergarten in very early childhood does not appear to increase risk. When a boy's aggressive behavior in the early grades is combined with isolation or withdrawal, the risk of problems in adolescence is even greater. This increased risk also applies to aggressive behavior combined with hyperactivity or attention deficit disorder. This risk factor also includes persistent antisocial behavior in early adolescence, like misbehaving in school, skipping school, and getting into fights with other children. Young people, both girls and boys, who engage in these behaviors during early adolescence are at increased risk of drug abuse, juvenile delinquency, violence, school dropout, and teen pregnancy.
Favorable attitudes toward drugs (IR2)	During the elementary school years, most children express anti-drug, anti-crime, and pro-social attitudes and have difficulty imagining why people use drugs or engage in antisocial behaviors. However, in middle school, as more youth are exposed to others who use drugs and engage in antisocial behavior, their attitudes often shift toward greater acceptance of these behaviors. Youth who express positive attitudes toward drug use and antisocial behavior are more likely to engage in a variety of problem behaviors, including drug use.
Rebelliousness (IR3)	Young people who do not feel part of society, are not bound by rules, don't believe in trying to be successful or responsible, or who take an active rebellious stance toward society, are at higher risk of abusing drugs. In addition, high tolerance for deviance, a strong need for independence and normlessness have all been linked with drug use.
Friends who use drugs (IR4)	Young people who associate with peers who engage in alcohol or substance abuse are much more likely to engage in the same behavior. Peer drug use has consistently been found to be among the strongest predictors of substance use among youth. Even when young people come from well-managed families and do not experience other risk factors, spending time with friends who use drugs greatly increases the risk of that problem developing.
Gang involvement (IR5)	Youth who belong to gangs are more at risk for antisocial behavior and drug use.

Early initiation of drug use (IR6)	Early onset of drug use predicts misuse of drugs. The earlier the onset of any drug use, the greater the involvement in other drug use and the greater frequency of use. Onset of drug use prior to the age of 15 is a consistent predictor of drug abuse, and a later age of onset of drug use has been shown to predict lower drug involvement and a greater probability of discontinuation of use.
Constitutional factors (IR7)	Constitutional factors may have a biological or physiological basis. These factors are often seen in young people who engage in sensation-seeking and low harm-avoidance behavior and those who demonstrate a lack of impulse control. Fetal alcohol and drug exposure, environmental poisoning, and brain injuries are some other examples of constitutional factors. These factors appear to increase the risk that young people will abuse drugs, engage in delinquent behavior, and commit violence.
Individual/Peer Protective Factors	
Bonding to peers with healthy beliefs and clear standards (IP1)	Young people who feel that they connected to a peer group with healthy beliefs and clear standards are less likely to engage in substance use and other problem behaviors.
Attachment to peers with healthy beliefs and clear standards (IP2)	The people with whom young people have bonds need to have healthy beliefs about substance use and other problem behaviors, as well as clear, positive standards for behavior. The content of these standards is what protects young people. When peers set clear standards for behavior, when these standards are widely and consistently supported, and when the consequences for not following the standards are consistent, young people are more likely to follow the standards.
Opportunities for prosocial involvement (IP3)	Young people who associate with peers who engage in prosocial behavior are more protected from engaging in antisocial behavior and substance use.
Increase in social skill (IP4)	Young people who are socially competent and engage in positive interpersonal relations with their peers are less likely to use drugs and engage in other problem behaviors.

Prevention Strategies List

***THIS IS NOT A COMPREHENSIVE LIST: This is to give you an idea of what may be considered for a specific strategy domain.**

Education
Parenting and Family Management
Small Group Sessions
Ongoing Classroom Sessions
Peer Leader/Helper Programs
Education Programs for Youth Groups
Mentoring
Preschool ATOD Prevention Programs
Provider training
Patient training
Environmental Strategies
Availability (Rx)
Enforce Prescription laws
Address Over-prescribing of Prescription Narcotics
Social Access/Availability
Curfews
Strengthen laws against provision of alcohol
Enforce laws against provision of alcohol
Teen party ordinances
Social host liability
Controls on alcohol service at private parties
Alcohol restrictions at community events

Retail Access/Availability
Strengthen minimum age of purchase laws for alcohol
Limit and restrict the location and density of retail alcohol outlets
Conditional use permits/land use ordinances for alcohol outlets
Regulations or bans on home delivery of alcohol
Checking age identification for alcohol
Increase beverage servers' legal liability
Minimum age of seller requirements
Prohibiting anyone under age 21 from bars
Increase price or taxes on alcohol
Promotion
Alcohol advertising restrictions in public places
Prohibition of alcohol sponsorship of events and other promotions
Countermarketing/counteradvertising campaigns
Media advocacy
Media literacy
Criminal Justice/Enforcement
Compliance checks of alcohol retailers
Administrative penalties for businesses that violate law
Party Patrols (specific law enforcement units to address parties)
"Shoulder-tap" enforcement programs
Enforce impaired driving laws
Sanctions and monitoring for convicted drunk drivers
Sobriety checkpoints
Enforce open container laws
Apply appropriate penalties to those in possession of alcohol
"Cops in shops"

Community/Social Norms
Alcohol use restrictions in public places
Social norms campaigns
Social marketing
Media campaigns
College campus policies (offer/require substance-free housing)
Individual Factors/Perceived Risk
Revoke license for impaired drivers
Media campaigns to education on current laws and penalties
ATOD warning posters
College campus policies (parental notification of campus alcohol infractions)
Media campaign to impact individual attitudes
Alternative Activities
Alcohol/Tobacco/Other Drug Free Events
Youth/Adult Leadership Activities
Community Drop-in Centers
Communities Service Activities
Community Mobilization
Community and Volunteer Training
Systematic Planning
Multi-Agency Coordination and Collaboration/Coalition
Community Team Building
Assessing Services and Funding
Problem ID and Referral
Employee Assistance Programs
Student Assistance Programs

DUI/DWI Education Programs

Information Dissemination
Clearinghouse/Information Resource Centers
Resource Directories
Media Campaigns
Brochures
Radio and TV Public Service Announcements
Speaking Engagements
Health Fairs or Other Health Promotion
Information Lines/Hot Lines